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Carr, Sarah and Patel, Meena (2016) Practical guide: progressing transformative co-production in mental health. Other. National Development Team for Inclusion, Bath. . [Monograph]

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## Practical Guide:

# Progressing transformative co-production in mental health



National Development Team for Inclusion



“transformation  
of power  
and control”

Co-production in mental health is about progression towards ‘the transformation of power and control’ (Slay & Stephens, 2013). It requires thinking about people, power, partnerships, resources and risk in ways that are very different to what has gone before in mental health services. It implies relocating power to mental health service users, survivors, their organisations and communities and this has implications for services and practitioners. To ensure full collaboration, the co-production process should achieve equality and parity between all those involved. Change happens during the process of co-production as well as being a consequence of it.

There is no single, universal model of co-production and the way co-production is done is specific to the task, context and the people involved, so this is not a ‘how to’ guide. Instead the aim is to set out some practice-based advice on what needs to be considered for progressing towards ‘transformative co-production’, specifically in mental health. The advice is presented as ‘steps’, illustrated by practice lessons from what a number of different people and organisations in the field have tried and tested. The guide also includes three case studies from different mental health settings drawn from the practice examples.

This guide is aimed at everyone with a practical interest in making co-production work in mental health services. It is particularly designed for those at the frontline such as mental health service users, carers and their organisations as well as practitioners and managers who want to engage with and understand transformative coproduction. It was written in collaboration with service users and their organisations, NHS mental health practitioners and those working in community-based mental health organisations and initiatives.

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## identifying the unique challenges in mental health services

### Background:

As a result of preparatory work on co-production in mental health with the New Economics Foundation and Mind, the National Development Team for Inclusion (NDTi) received funding from the Esmée Fairbairn Foundation for a collaborative project to demonstrably increase understanding of co-production in mental health.

This project builds on the [New Economics Foundation and Mind report 'Co-production in mental health: A literature review.'](#) (Slay & Stephens, 2013)

A collaborative working group of service users and their organisations, carers, practitioners, policy and research experts was established to:

- Explore the unique challenges for and responses to co-production in mental health services and develop a position paper on this
- Develop a practical, evidence-based resource(s) on how co-production can be understood and implemented in mental health

The project collaborative working group was very keen to hear about examples of successful co-production and attempts that did not work, from within and outside statutory or mainstream mental health services.

[The position paper](#) looked at some of the research evidence on co-productive approaches in mental health originating with service users and survivors. It identified a number of unique challenges for co-production in mainstream mental health services. These were:

- Resistance to change
- Restrictive administrative procedure and professional practice
- Avoidance of challenge, confrontation and emotional expression
- The demand to conform to institutional rules, roles and cultural norms

The findings from the position paper informed the template of questions used to guide and gather practice examples, so that the examples included information on how those particular challenges were addressed.

In order to gather evidence from practice, the project team called for examples of successful co-production and attempts that did not work, from within and outside statutory or mainstream mental health services.

The project team asked for feedback from:

- People who identify as having a mental health problem, or as service users/survivors
- User-led organisations (ULOs)
- Non-user led mental health campaigning organisations
- Local authority or NHS commissioners (including Clinical Commissioning Groups)
- NHS Trusts
- Local authorities
- Voluntary and community sector mental health providers
- Specialist voluntary and community sector groups and organisations (such as those supporting black and minority ethnic [BME] or lesbian, gay, bisexual and transgender [LGB&T] people)

The details of the methodology, practice example selection process and the question template can be found in Appendix One.

[A checklist](#) of key questions to consider and actions that can be taken when thinking about and starting a cop-productive project complement this guide.

‘The quiet superiority of the medical sickness model in mental health system cultures is a hindrance’

## Practice lessons and steps towards transformative co-production in mental health

The initial analysis of the twelve practice examples resulted in a set of key practice lessons for transformative co-production in mental health derived from what the practice examples indicated worked well and what did not work well.

This was further developed in a one-day workshop with a self-selecting team from the collaborative working group.

The group included a member of a user-led organisation, a mental health practitioner from an NHS Trust and a Timebank manager. The team analysed the practice lessons, drawing on their own experiences of co-production in or with mainstream mental health services.

The key practice lessons below form steps towards transformative co-production in mental health:

Putting these steps into practice is not simple. Paying close attention to the lessons from practice will help to build understanding, trust and confidence, all of which are essential prerequisites for progressing transformative co-production.



### Step 1. Setting the scene: Understanding the context and environment in which co-production is going to place

- Power, hierarchy and authority
- Institutional systems and resistance
- Leadership commitment and senior support

### Step 2. Coming together: Creating the right conditions for co-production to work

- Time, preparation, planning and clarity of purpose
- Common and shared values, aims and language
- Ground rules for group working
- Navigating roles and boundaries
- Process and participant facilitation
- Payment and welfare benefits
- Sharing the defining and decision-making

### Step 3. Working together: Achieving parity and genuine collaboration

- Trust, honesty, communication and transparency
- Reviewing, learning and making mistakes
- Equality, assets and experience
- Practical, flexible frameworks
- Emotional and psychological support and facilitation
- Staff support and perspectives
- Service user and/or carer support and perspectives
- Addressing challenge and tensions

The following sections give some of the practice lessons for each step, with direct quotes from the examples to illustrate or illuminate specific highlights.



## Step 1. Setting the scene: Understanding the context and environment in which coproduction is going to take place

Understanding the wider context of the mental health system, cultural forces and the broader environment in which co-production will happen is important for assessing the challenges and possibilities for coming and working together.

Frameworks such as the ‘alternative ladder of participation’ in the New Economics Foundation and Mind report ‘Co-production in mental health: A literature review’, can help with assessing existing service user participation initiatives in terms of co-production (Slay & Stephens, 2013 p.4). These frameworks can help with identifying what has worked and not worked and what needs to change so that people have better experiences of collaborative working and can see tangible differences as a result of their co-productive effort.

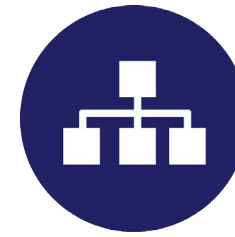
### Power, hierarchy and authority

Evidence suggests that understanding how power, authority and structures of accountability work in mainstream mental health services needs is crucial, particularly for understanding the potential resistance to change.

**“We have been determined that it should be a bottom-up rather than top-down development through supporting a group of people to decide for themselves the organisational form and objectives and provide support to get them off the ground”**

Evidence from practice shows that co-production has the potential to promote the equality and mutuality which are critical to achieving lasting change.

**“Co-production breaks down barriers around stigma...a sense of all working together...no hierarchy. How it should be, we are people after all”**



## Institutional systems and resistance

Institutional systems, bureaucratic processes and resistance to change can and do pose significant challenges to co-production in mental health, even for smaller initiatives. Identifying and addressing some of the issues from the outset can lead to a better experience for all involved in co-production with the potential to result in meaningful change.

‘There were some challenges that were encountered by the team members with lived experience, especially when accessing the ward. Although official members of the team, they were not provided with Trust ID badges, which caused some concern about authorisation and access to facilities’

### Case example: Experience-based co-design on an NHS Trust inpatient mental health ward

This project addressed hospitalisation in early psychosis and service improvements developed in collaboration with a range of stakeholders, including service-users, carers, community and inpatient staff, and management. The team used an adapted form of experience-based co-design (EBCD), a participatory action-research method for collaboratively improving health care services. Service user, carer and staff experiences were analysed and converted into an accessible and concrete list of ‘touchpoints’, which are crucial moment that makes a difference (good or bad) to someone’s experience of the environment or process.

Twenty ‘feedback groups’, consisting separately of inpatient staff, community mental health staff, NHS managers, family members, or service users discussed the ‘touchpoints’ and participants chose their ‘priorities for change’. All feedback groups reached consensus fairly easily and recognised the typical difficulties faced by young service-users being hospitalised.

The co-design event was the critical point in EBCD and involved developing a shared consensus for service improvement (derived from staff, service users and carers’ experiences) and collaborating on action plans for change. It involved service users, family members, inpatient and community mental health staff, and managers as collaborative partners to develop plans to address the prioritised areas for improvement. Service user and carer volunteers from the feedback groups reminded participants about the key priority areas they had identified, to set the tone of the event, and to prime the participants to work together respectfully.

After the co-design event, action plans were given to a steering group, which included NHS staff, service users, and family members. The steering group was tasked with monitoring and supporting the implementation of the action plans over the next 12 months, although we continued to attend steering group meetings and support the implementation process. (adapted from Larkin et al, 2015)





## Leadership commitment and senior support

Leadership at all levels and consistent personal and professional senior staff commitment to the process is needed, so that they support co-production and change even if it is challenging. Obtaining wider support and understanding at all levels of the organisation, highlighting the benefits of co-production is critical for success.

Service users and their organisations and carers can assume leadership roles in co-production and require support and investment for independent collective organisations, which provide important power-bases.

*“Leaders must believe in co-production, see the wisdom in it and make a personal and professional commitment”*

## Step 2. Coming together: Creating the right conditions for co-production to work

Bringing different people together to work is a distinct step in progressing transformative co-production in mental health, particularly as the process should be about achieving equality and parity between all those involved.

The evidence suggests that in mental health, there is a risk that those involved in co-production will be expected to conform to institutional rules, roles and cultural norms.

There may be a risk that restrictive administrative procedure and professional roles compromises the degree to which service users and/or carers can achieve parity and equality during the process. Any risks relating to co-production need to be identified and explicitly tolerated by all those involved.

A ‘setting up’ stage of preparation is needed to explore and address these issues, agree commitment and how people will work together so they are ready and prepared to do so.



## Time, preparation, planning and clarity of purpose

**Spending sufficient time together at the start to prepare is critical. Consider what needs coproducing and why. This ensures that everyone involved has a clear understanding about what they have come together for and why.**

*“Great care was taken to prepare service users, families and staff very carefully for what to expect from the event and we ensured that support was available for anyone who needed it”*

Make sure all the right people with the necessary skills, experience, values and attitudes are involved from the outset, including life experience. Start with service users and survivors and consider possible ‘cycles of availability’ as people’s mental health can fluctuate, so co-production in mental health needs realistic and negotiated time scales if it is to be successful.

*‘We are often expected to have results or outputs quickly and this kind of work can delay this occurring’*

**Case example: NHS Trust Collaboration for Leadership in Applied Health Research and Care (CLAHRC) – Improving the physical health of people admitted to a mental health ward**

A team of healthcare professionals and service users was formed to consider how to improve the physical health of patients admitted to a mental health ward in an NHS Mental Health Trust hospital. Service users, or team members with lived experience, were recruited at the start of the project and were keen to be actively involved. When it was identified that an intervention was required to facilitate shared-decision making between healthcare professionals and patients, it was obvious that its success and acceptability would require its development through co-production.

The project was explicitly established to include a multi-disciplinary team that covered both the ward team and also community mental health teams. The team was provided with quality improvement advisors and project management support, which significantly aided the operational delivery of the project. The use of the quality improvement tools also provided a framework through which the team could engage with the task of improving physical health for patients and explore, develop and test potential solutions.

The co-production of the patient held booklet, ‘My physical health record explained’ through collaborative working between service users and professionals has been a key output from the project.



## Common and shared values, aims and language

Developing a common and shared understanding of and commitment to a set of values is a key to successful co-production. This needs to include a shared definition or understanding of what co-production is, and how it differs from what has gone before. This type of preparatory work is about building trust, confidence and a sense of equality. Co-defined and shared aims are very important and the use of technical language or jargon should be avoided as it creates divisions and makes discussion inaccessible.

*“At initial meetings there were consensus generation exercises and work on unpacking assumptions while identifying activities to meet the aims of the project”*



## Ground rules for group working

Agreeing a set of supportive, negotiated ground rules for collaborative working is highly recommended, including how any disagreements and challenges will be worked through by the whole group.

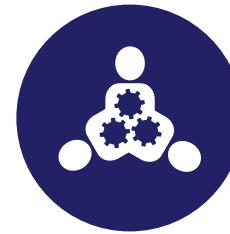
*“We formed ground rules of expected behaviour at the outset (respect etc)”*



## Navigating roles and boundaries

Transformative co-production requires a shift away from medicalised ‘us and them’ divisions between practitioners and service users; this requires a move away from traditional, organisational roles towards collaboration based on equal but different types of skills and expertise. This may be an unsettling or disruptive experience, especially for staff, and boundaries need to be carefully negotiated during the process.

*“For some staff, this was their first experience of working so directly with people who had themselves been former users, and the impact was noticeable as relationships were built and assumptions about professional and patient roles were replaced by more collaborative working relationships”*



## Process and participant facilitation

If co-production looks challenging to achieve in the circumstances, external facilitators with expertise in co-production can support people to work together collaboratively as a group. This includes building trust, parity and understanding between service users and staff, especially during the preparation and early stages.

*“Business as usual, with formal meetings and agendas in spaces associated with services lead to inhibition and a lack of creativity”*



## Payment and welfare benefits

All those involved in co-production should be equally valued and in many cases this means paying people fairly for their time and expenses. However, some service users and carers may be in receipt of welfare benefits and will need accurate information and advice about how benefits rules affect payment and expenses.

*“Open and honest discussion about value, esteem, equality and payment of peer workers.”*



## Sharing the defining and decision-making

Decisions about what needs to change must be made equally with service users and/or carers at the very beginning. Defining the problems and what needs to change as well as solutions has to be done in a fully inclusive, collaborative way. A top-down, controlling approach will not work.

*“The day was fun but we also let attendees tell us what they felt was important. We didn’t have a prescriptive agenda”*



### Step 3. Working together: Achieving parity and genuine collaboration

Working together in equal collaboration is the core activity of any transformative co-production initiative in mental health.

Evidence suggests that in mental health, there is a risk that there will be avoidance of challenge, confrontation and emotional expression during the process.

Co-production may be about loss as well as gain and involves changes in power as part of the process, so it could feel emotionally difficult, risky or disruptive for some participants.



#### Trust, honesty, communication and transparency

Clarity and openness about what is and what is not possible in the co-produced activity; about the extent of power and equality; the limits and possibilities for achieving change; how participants feel when working together and acknowledgement of tensions is needed.

***‘If there is no transparency on how much co-production there can really be with service users as equals then it will never work’***

Co-production in mental health requires building confidence and trust between all those involved, and this means facilitated, honest dialogue and communication.

***‘Clear communication between staff or managers and service users involved with co-production is crucial, particularly when there are difficulties: ‘I left feeling I had done something wrong, they decided to carry on delivering the course without me...if I got something wrong, it would have been good to know what it was’***



### Reviewing, learning and making mistakes

Co-production is a continuous learning process for all involved. Being willing to take risks and make mistakes; reviewing, reflecting and learning from them, and making changes necessary throughout the process is vital for coproduction in mental health.

***“Encourage an attitude that it would be OK if something went not according to plan, that it was OK to be human and make mistakes”***



### Equality, assets and experience

Co-production is about valuing all contributions equally, mutual respect and recognising that all people have skills, assets and experience that are valuable and necessary for co-production. Equal status and mutual respect between co-producers should be achieved through the process.

Contributions are not necessarily dependent on the ‘roles’ of service user and practitioner. For service users this may be more than their ‘lived experience’ of mental distress and service use, and include skills and expertise from their occupation or interests. For staff this may be more than their professional expertise, and include their own personal experiences and interests.

***‘We aimed for all people to feel valued – no-one was asked to say who they were on the day (patient, carer or staff)’***

## Case example: Peer-led mental health support provider project

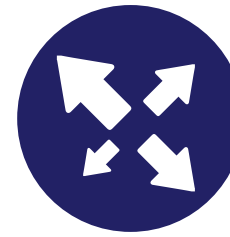
A peer led, personality disorder service was established via a housing organisation to support people with ongoing personality related difficulties to access social activities, voluntary work, education, training, employment and groups.

The service operates between 9am and 5pm Monday to Friday and offers one-to-one key work sessions, personal development and vocational groups. They also run a weekly peer support group, run and facilitated by ex service users who have experienced personality disorder first hand. The two Specialist Support officers are encouraged to be open and authentic with service users, whilst maintaining professional boundaries.

The success of the service has been due to both the staff skills and the service users' lived experience. Having staff that enabled an open environment to allow service users to feel heard and have their knowledge and skills used as assets and acknowledging their expertise rather than an old fashioned approach that staff have all the answers. The ethos was from the start that we all have strengths but bringing these together only made the service stronger.

Currently, all peer support groups are co-facilitated by peers. This took some time to implement as service users' needed to build their confidence to become peer facilitators as well as work on their own issues that could prevent them from feeling able to fulfill that role.

Every aspect of the service is co-produced to ensure that customers and peer facilitators feel that they are fully included. From setting up group ground rules, picking the group location and timings of the groups and of course the aims of the groups.



## Using Practical, flexible frameworks

While the co-production process is unique to the situation and the people involved, using flexible mental health coproduction frameworks such as the National Survivor User Network's (NSUN) 4PI National Involvement Standards can help structure the process (NSUN, 2015).

Experienced-Based Co-Design is another framework that can be helpful for organising co-production activities in mental health (Larkin et al, 2015; King's Fund, 2013), as can drawing on theories of how to bring different groups together to reduce prejudices and misunderstanding, such as the 'Intergroup Contact Theory' (Allport, 1954).

*'Flexible frameworks like the National Survivor User Network's 4PI Involvement Standards framework help support co-production. The Action Effect Diagram helped all participants understand the aim and process of quality improvement'*



## Emotional and psychological support and facilitation

Because it involves shifts in power and authority and blurring the boundaries of traditional roles, the experience of the co-productive process in mental health can potentially be emotionally and psychologically challenging for all involved. The need for this type of support should be anticipated, explored and provided for if the process is to be successful in mental health. When done badly co-production can be damaging to service users and staff.

*'The inter-personal dynamics of care influence co-production in mental health, including feelings and shared experiences of fear and uncertainty.'*

*'We ensured that [someone] sat on each table to deal with any emotional or difficult situations that arose'*



## Staff support and perspectives

Co-production in mental health requires that staff step out of their traditional roles and in doing so take some professional or personal risks. Preparation and support for staff needs to be considered and addressed as part of the process.

*‘[The staff] felt that they had no clear direction and had been used to working in an environment that had not enabled them to use their skills and gifts’*



## Service user and/or carer support and perspectives

Co-production in mental health requires that service users and carers gain equality, power and authority as part of process. Preparation and support for service users and carers has to be considered and addressed, particularly for people who have particular experiences of powerlessness, discrimination and marginalisation.

*‘Service users were encouraged to develop their own voice, share their lived experience in the groups and give power to their difficulties within the shared and common environment of the group’*



## Addressing challenges and tensions

Because the process is about changing relationships, transformative co-production in mental health may result in challenges and tensions during the collaboration.

*‘We were conscious of the current context of inpatient care in the United Kingdom and that relationships between staff, service users and carers may be strained’*

It is vital that challenge is anticipated and tensions are recognised, explored and addressed as a group with honesty and openness.

*‘It may prove challenging for some staff to hear just how strongly the service users and carers felt about the problems on the wards’*

“We  
learnt it  
could be  
done”

Practitioner,  
NHS Trust  
Recovery College  
training programme

## Conclusion

There are unique challenges in mainstream mental health services for progressing towards and achieving transformative co-production, but the practice lessons and examples included in this guide show that it can be done. The following points highlight the key issues and lessons from practice examples.

Understanding the wider context and environment in mental health is vital. Mental health services wishing to use co-production to make small or large changes and improvements need to start by examining how and why they work in particular ways, and be prepared to accept and respond to challenge from service users and from staff.

In mental health, the co-production process itself can be challenging because it is about achieving parity and equality between those involved. Some aspects can be readily dealt with, such as agreeing ground rules, but many aspects are about sharing power, roles and relationships that require subtle interpersonal skills like navigating roles and boundaries. Contributions are not necessarily dependent on the traditional service ‘roles’ of service user and practitioner. Coproduction may require facilitation involving skills that are not often used in hierarchical mainstream mental health services.

Asking people to step outside their usual ‘practitioner’ and ‘service user’ roles to share power and work together as equals, can mean disruption or discomfort. Both service users and staff need to feel safe to express themselves honestly, to take risks, make mistakes and learn from them. Flexible coproduction frameworks like the National Survivor User Network (NSUN) 4PI National Involvement Standards (NSUN, 2015) can help with facilitating the process if they are not imposed and everyone agrees to use them.

Co-production in mental health is about a ‘transformation of power and control’. The process of equalising power and valuing diverse expertise and experience can be challenging and takes time. It is about a journey of discovery and growth where the change during the process is as important as at the outcome. During the process communication, relationships, perceptions and attitudes can be challenged and transformed.

Many of the practice examples show the potential for coproduction to work in different mental health settings for achieving different things, but in doing so those involved in the process came to realise

*‘the success of co-production and what can be achieved through hard work, patience, reflection and a willingness to acknowledge mistakes, personal limits and boundaries and the grace to admit when something feels scary or unmanageable’*

## Next steps

A [checklist](#) of areas for consideration and action that can be taken when working on a co-productive project complements this guide.

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## Appendix One: Methodology and Question Template

An eight-week call for mental health co-production practice examples was disseminated through the various networks of collaborative working group members. These included Mind, New Economics Foundation, the National Survivor User Network (NSUN), National Voices, NDTi and the Think Local Act Personal partnership. The call for practice was also disseminated via the Twitter accounts of some of the collaborative working group members and members of the project team also followed up specific practice examples they were aware of.

The practice examples were gathered using a template of guideline questions based on some of the findings from the position paper, as shown below. The respondents did not have to answer all the questions, and these were included to guide people's thoughts.

- 1. Type or nature of activity that was, or is being coproduced**
  - Who initiated and/or led the activity?
  - What was it that you were coming together to co-produce? (i.e. individual care and support, or wider community and/or service commissioning and planning).
  - Who defined the issue or problem to be tackled?
- 2. Why and how was it decided that a co-productive approach was the best way to do what was needed?**
  - What was envisaged would be achieved by using this approach?
- 3. Developing a common and shared understanding**
  - Was there a shared understanding and agreement among service users, frontline staff and clinicians/professionals of the problem/issue being tackled?
  - How did the process of coming to a shared understanding or finding common ground feel for staff and for service users? How were any disagreements dealt with?
  - Were service users able to express their stories and use their lived experience in developing a shared understanding?
  - Were staff able to express their stories and use their lived experience in developing a shared understanding?
  - Was it clear at the outset, or did it become clear during the process what changes were needed for people with lived experience of mental health, within communities and wider service system?
  - How did those involved define the changes needed and agree the process of getting there?
- 4. Outcomes and process**
  - Was there an explicit recognition of the knowledge, expertise, assets, strengths and contribution of everyone involved?
  - Please give one or two examples of how different contribution(s) were actively sought and used to generate a better understanding, or in co-creating solutions.
  - If it arose, what was the response to any challenges, or emotional expression from people with lived experience and how was that integrated into learning about what needed to change and how?
  - Were staff able to be honest about their own personal and frontline experience?
  - Were people with lived experience expected to conform mental health service or formal meeting rules and use a particular language to be heard, or was a different kind of relationship and communication forged?
  - Please describe what happened.**
  - Were all the right people together from the outset? How was this decided? What was done to ensure that all the right people were involved?
  - How were other practical issues such as access (information, timing of sessions, location and choice of venues for meetings), payment as recognition of value for time and expenses (with regard to welfare benefits) and facilitation of meetings considered?
  - What outcomes were achieved for individuals and service systems? How was change demonstrated and communicated to all those involved?
- 5. Tracking progress**
  - How was progress tracked? This includes progress towards achieving the desired outcome(s) for service users and service system(s) and the process itself, looking at what was working and not working from different perspectives, including
    - a shift in power dynamic and increase in trust between professionals and service users;
    - openness and capacity for challenge;
    - recognition of assets and expertise;
    - changing relationships;
    - growing confidence and skills development for all parties.



6. Barriers and challenges

- Please describe the main barriers and challenges experienced and how they were overcome?
- Were there any challenges and barriers that could not be overcome? Why was that?

7. What was learnt and by whom? What would you do differently next time?

The questions in the template were used to support an initial thematic analysis of the practice examples, from which practice lessons to inform the ‘steps towards’ were derived. The initial analysis was further developed in a one day workshop with a self-selecting team from the collaborative working group. The group included a member of a user-led organisation, a mental health practitioner from an NHS Trust and a Timebank manager. The team further analysed the practice lessons, drawing on their own experiences of co-production in or with mainstream mental health services. Practice examples that were not relevant to mental health or did not use the template or contain sufficient detail to be analysed using the template questions had to be excluded.

Response profile and selection process

In total, eighteen practice examples were finally submitted. Eight were from service users or carers and their organisations and ten were from NHS Trusts, mental health practitioners or non-user led mental health provider organisations.

The eighteen practice examples included:

- five NHS Trust Recovery Colleges (mentioning peer support initiatives),
- an Academic Health Science Network and NHS Trust first episode psychosis pathway project
- two examples of a user-led organisations or service user being involved in Local Authority mental health service commissioning
- an NHS Trust carer consultation initiative,
- a carer advocacy experience within an NHS Trust,
- an example of service user inclusion in crisis care information design,
- a NHS Trust transgender health needs assessment,
- an NHS Trust Collaboration for Leadership in Applied Health Research and Care (CLAHRC),
- a Clubhouse project,
- a community sector change facilitation organisation working with a Local Authority on commissioning housing provision for people with mental health problems,
- a Timebanking project,
- a peer-led mental health support and training provider project, and
- an example of experience-based co-design on an NHS Trust inpatient mental health ward

Some of the respondents used the call for practice examples as an opportunity to highlight concerns about NHS mental health services and service user involvement. Of the eight practice examples submitted five included accounts of negative experiences of mental health services that involved formal complaints or use of advocacy services; negative or disempowering experiences; and the impact of changes to welfare benefits and cuts to local support services or user-led organisations on people’s ability to be involved in co-productive initiatives.

Twelve of the practice examples were finally included in the analysis as they used the template or had enough detail to be analysed using the template questions. Five practice examples that did not use the template or were not detailed enough were followed up and one person responded with further detail within the deadline.

Five of the final includes were from service users, carers or their organisations and seven were from NHS Trusts, mental health practitioners or non-user led mental health provider organisations. There were no specific examples relating to projects with or by black and minority ethnic communities or with or by lesbian, gay or bisexual people. One example of an NHS Trust health needs assessment pathway for transgender people was submitted, but had to be excluded as it was a presentation that did not contain sufficient information on co-production for analysis using the template questions. All practice examples related to adult mental health services. The level and depth of detail about the co-productive process given in the templates by respondents was variable. Overview of included practice examples

The twelve practice examples finally included were as follows:

- three NHS Trust Recovery Colleges (mentioning peer support initiatives)
- an NHS Trust Collaboration for Leadership in Applied Health Research and Care (CLAHRC)
- an example of experience-based co-design on an NHS Trust inpatient mental health ward
- an Academic Health Science Network and NHS Trust first episode psychosis pathway project
- a community sector change facilitation organisation working with a Local Authority on commissioning housing provision for people with mental health problems
- two examples of a user-led organisations or service user being involved in Local Authority mental health service commissioning
- a Clubhouse project
- a Timebanking project

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Grateful thanks to all those who shared their practice examples and mental health coproduction experiences with us.



The project was funded by a grant from the Esmée Fairbairn Trust





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